SECTION 7000
FUNDING OF OUTPATIENT MEDICAID DEFICIT IN GOVERNMENTAL HOSPITALS

7001 GENERAL INTRODUCTION

A hospital operated by the State or a local government in Wisconsin may receive reimbursement from the Wisconsin Medicaid program for the portion of a total operating deficit that is attributable to providing outpatient hospital services to Wisconsin Medicaid recipients. This is refered to as the deficit reduction payment in this section. The amount paid to the hospital will be the federal Medicaid financing share of the deficit to the extent the governmental unit has provided sufficient funding to serve as the non-federal match. This section describes the criteria to qualify and how the reimbursement amount will be calculated. This reimbursement is available for hospital fiscal years beginning on and after January 1, 1996 and will be determined at the time the final settlement is calculated under §4000. An interim payment is available according to §7080 below. In case of federal disallowance of any amount paid to hospitals under this section, the Wisconsin Medicaid program will recoup the disallowed FFP monies from the hospitals.

7010 QUALIFYING CRITERIA

A hospital will qualify for a deficit reduction payment if:

(a) the hospital is operated by the State or a local government in Wisconsin,

(c) it incurred a deficit from providing Medicaid outpatient services (described in §7020 below),

(b) it incurred a total hospital operating deficit (described in §7030 below), and

(b) the governmental unit that operates the hospital provided funds to serve as match for the federal financial participation (FFP) (described in §7050 below) .

7020 DEFICIT FROM PROVIDING MEDICAID OUTPATIENT SERVICES

The deficit from providing outpatient services to Wisconsin Medicaid recipients (that is, the Medicaid deficit) is the amount by which cost, reduced for excess laboratory cost, exceeds the payment for the Medicaid outpatient hospital services. Excess laboratory cost is the amount by which the costs of laboratory procedures exceed the clinical diagnostic laboratory reimbursement for those procedures. Clinical diagnostic laboratory reimbursement is the lower of laboratory fee schedule amounts of the Medicaid program or the hospital's charges for the procedures (as defined in §3000). The cost of Medicaid outpatient services is identified from the hospital's audited cost report for the final settlement year. Total payment is the total of the reimbursement provided under §4000 through §6000 herein for outpatient services.

7030 TOTAL OPERATING-DEFICIT

A hospital's total operating-deficit (or profit) will be identified from the hospital's financial statements for the settlement year. The deficit or profit will be adjusted to take-out deficit reduction payments which were recognized as revenue in the financial statements. (It should be noted that payments made by the Wisconsin Medicaid program for which the governmental unit provided the matching funds may have been recognized as revenue in those financial statements and should be excluded to establish the appropriate deficit amount for use in calculating reimbursement under this section.)

7040 DETERMINATION OF REIMBURSEMENT AMOUNT

A hospital qualifies for a deficit reduction payment that is equivalent to the federal financing portion (FFP) of either its Medicaid deficit or its total operating deficit, whichever is the lesser deficit amount. The non-federal portion of the deficit amount must be funded by the governmental unit that operates the hospital. If necessary, the deficit reduction payment will be reduced to assure that the funding provided by the governmental unit equals the funding proportion (that is, the matching rate) required of State or local governments by §1902(a) of the federal Social Security Act.

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7050 FUNDING OF THE NON-FEDERAL PORTION

The governmental unit's funding of the non-federal portion must be provided by public funds that are not federal funds or, if federal funds, are federal funds authorized by federal law to be used to match other federal funds. As required by federal regulations at 42 CFR §433.51, the governmental unit which operates the hospital must certify that the amount of funding provided by the governmental unit are expenditures eligible for FFP.

7060 LIMITATION TO CHARGES

The combined total of: (a) the deficit reduction payment made by the Wisconsin Medicaid program, (b) the non-Federal portion of that payment provided by the governmental unit and (c) all other payments to the hospital for outpatient Medicaid services will not exceed the hospital's total charges for the services for the settlement year. If necessary, the deficit reduction payment will be reduced so the combined total payments do not exceed charges.

7070 AGGREGATE LIMITS ON DEFICIT REDUCTION PAYMENT

The deficit reduction payments to all qualifying hospitals will be proportionally reduced based on the total of such payments if such a reduction is necessary so that payments to all hospital combined do not exceed the aggregate limits.

The aggregate deficit reduction payments made to hospitals for outpatient Medicaid services, during any twelve-month period of July through June will not exceed the amount $3,300,000 reduced for deficit reduction payments made for inpatient services (under state plan attachment 4.19A).

The aggregate deficit reduction payments made to hospitals under this section will not exceed the amount for which FFP is available under federal upper-payment limits at 42 CFR §447.321.

7080 INTERIM PAYMENTS PENDING THE OUTPATIENT FINAL SETTLEMENT

Deficit reduction payments are available for hospital fiscal years beginning on and after January 1, 1996 and will be determined at the time the final settlement is calculated under §4000. A hospital's final settlement is not calculated until an audited cost report is available for the hospital's fiscal year. This may be two to three years after the fiscal year ends. Because of this delay, hospitals operated by the State or a local government in Wisconsin may apply for interim deficit reduction payments after completion of their fiscal years. The Department will ask applying hospitals to provide financial information so that an interim payment amount can be determined in the same manner as is described above. As described in §7040 and §7050 above, the non-federal portion of any deficit amount must be funded by the governmental unit that operates the hospital and the governmental unit must certify that the amount of funding provided are expenditures eligible for FFP.

7090 HOSPITAL MUST REQUEST FUNDING

A hospital must apply to the Department for deficit funding under this section 7000. This requirement applies to final settlements calculated after July 1, 1998 for fiscal years beginning on or after January 1, 1996.

If Interim Funding Was Provided. If the hospital applied for and received interim deficit reduction funding under §7080 for the final settlement year, then the Department will proceed with determining deficit reduction funding at the time of calculating a final settlement.

If No Interim Funding Was Provided. If no interim funding was provided under §7080 for a hospital's final settlement fiscal year, the hospital must submit a written request for deficit funding. The "60 day rule" and the due date requirements for administrative adjustments, specifically §6301 and §6303, apply for this request. The request must specify the fiscal year for which the hospital wants deficit funding. The Department will determine if a hospital qualifies for deficit funding.

APPENDIX

EXAMPLE CALCULATION OF RATE PER OUTPATIENT VISIT and RURAL HOSPITAL ADJUSTMENT PER OUTPATIENT VISIT

	Period of Hospital's Base Year Cost Report			1/1/87 to 12/31/87
1.	CAPITAL COSTS (From Base year cost report, Worksheet B, Part II, Line 95 minus costs not related to hospital, lines 34 to 36 and 63 to 94)	$ 7,753,545		
2.	TOTAL COSTS (From Base year cost report, Worksheet C, Line 101 minus costs not related to hospital, Lines 34 to 36 and 63 to 94)	/ $ 82,494,987		
3.	RATIO CAPITAL COSTS TO TOTAL COSTS	= 9.40%		
4.	T-19 OUTPATIENT COSTS (From Base year cost report, Worksheet E-3, Part III, Line 8, Outpatient column)			$ 628,899
5.	T-19 OUTPATIENT COSTS (From Base year cost report, Worksheet E-3, Part III, Line 41, Outpatient column)		+	30,759
6.	2% OF 1990 OUTPATIENT PSYCH PAYMENTS		+	772
7.	TOTAL T-19 OUTPATIENT BASE YEAR COSTS (Lines 4 + 5 + 6)		=	$ 660,430
8.	10% CAPITAL REDUCTION (Line 3 x Line 7 x 10%)			($ 6,207)
9.	BASE YEAR COSTS WITH 10% REDUCTION (Line 7 minus Line 8)		=	$ 654,223
10.	T-19 OUTPATIENT VISITS (From Base year cost report, Supplement Worksheet I)		/	6,839
11.	BASE YEAR COSTS PER T-19 OUTPATIENT VISIT (Line 9 / Line 10)		=	$ 95.66
12.	APPROPRIATE INCREASE FOR BASE COST REPORT PERIOD (From §4200)		x	1.1598
13.	**RATE PER OUTPATIENT VISIT** (Line 11 x Line 12)		=	**$ 110.95**
14.	RURAL HOSPITAL ADJUSTMENT PERCENTAGE		x	15%
15.	**RURAL HOSPITAL ADJUSTMENT PER OUTPATIENT VISIT** (Line 13 x Line 14)		=	**$ 16.64**
16.	**TOTAL INTERIM RATE** (Line 13 + Line 15)			**$ 127.59**

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APPENDIX
PROCEDURES FOR PROCESSING ADMINISTRATIVE ADJUSTMENTS

The Department provides an administrative adjustment procedure that allows individual hospitals an opportunity to receive a prompt review of their payment rates for specific circumstances. The policies and criteria for administrative adjustments that apply to hospitals are provided in the following State Plan sections:

(1) For inpatient rates for hospitals in Wisconsin and major border status hospitals, see §11000 of the "Inpatient Hospital State Plan",
(2) For inpatient rates for minor border status hospitals and out-of-state hospitals, see §10400 of the "Inpatient Hospital State Plan",
(3) For outpatient rates, see §6000 of the "Outpatient Hospital State Plan".

This appendix outlines the procedures the Hospital Unit staff of the Bureau of Health Care Financing (we) will follow for processing administrative adjustment requests from hospitals. Under some circumstances, an interim administrative adjustment may be provided with a final adjustment calculated after the a required audited cost report is available. The procedures in this appendix apply to the calculation of interim and final administrative adjustments.

These procedures apply to any administrative adjustment request submitted by a hospital on and after July 1, 1996

28010 Receipt of Request For Administrative Adjustment

A request for an administrative adjustment must meet the following requirements:

(1) *The request must be submitted by the due date.* A due date is specified in the state plan sections listed above for each circumstance for which an adjustment may be requested.

(2) *The request must be sufficient*. The request must inform us:
  (a) as to whether the request applies to inpatient or outpatient rates,
  (b) the specific circumstance listed in the state plan for which the hospital is requesting an adjustment, and
  (c) the effective date of the rate to be adjusted or the outpatient final settlement period to be adjusted.

Upon receipt of a request for an administrative adjustment, we will review the request and, if necessary, contact the hospital regarding the following items:

(1) We will determine if the request was submitted by the due date. If not, we will notify the hospital either:
  (a) if the request is denied because it has not been submitted by the required due date, or
  (b) if "the 60 day rule" allows the adjustment to be effective at some date other than the effective date of the rate for which an adjustment is being requested. (The "60 day rule" is described in §11600 of the "Inpatient Hospital State Plan" and §6300 of the "Outpatient Hospital State Plan".)

(2) We will determine if the request is sufficiently clear. If not, we will contact the hospital for clarification and may ask the hospital to resubmit a sufficient request.

(3) We will assess the data needed to calculate the adjustment. If additional data is needed from the hospital, we will request additional data according to the procedure described in §28020 below.

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28020 Request For Additional Data

If we determine additional data is needed for the adjustment, we will contact the hospital to request the additional data and specify a due date for the hospital to submit it. The due date we specify will not be less than one month and not more than three months from the date of our request. However, if the hospital requests an extension and can justify that additional time is needed to provide accurate information, we may allow additional time for submitting the data.

If the hospital does not submit the data or an extension request within the specified time period, we will notify the hospital in writing that the administrative adjustment will be denied unless the hospital submits the requested data. With this notice, we will specify another due date for submitting the data of not less than two weeks and not more than one month from the date of this notice.

In order to calculate the administrative adjustment, we may find it necessary to request additional data more than once from the hospital. Each request for additional data will be handled as outlined above.

28030 Notification to the Hospital of Our Proposed Adjustment

After we have the needed data, we will calculate the adjustment and send a notification to the hospital of our proposed adjustment along with supporting worksheets.

We will request the hospital to review our proposed adjustment and respond only if the hospital disagrees with the calculations. We will specify a due date for a response of not less than one month and not more than three months from the date of our notification to the hospital of the proposed adjustment.

If the hospital responds with a disagreement to our calculations, we will attempt to settle the disagreement with the hospital as described in §28040 below.

If we do not receive a response from the hospital by the due date, we will deem our proposed adjustment accepted by the hospital and we will adjust the hospital's payment accordingly.

28040 If Hospital Disagrees With Our Proposed Administrative Adjustment

If the hospital disagrees with our proposed administrative adjustment, we will attempt to settle any disputes the hospital may have and reach an agreement. The process of settling disputes may continue until a mutual agreement is reached. It may involve our revising the adjustment one or more times. In the process of settling disputes, we may request additional data according to the procedures outlined in §28020 above.

28041 If We Do Not Revise the Disputed Adjustment.

If we do not revise the disputed adjustment, we will notify the hospital that no change will be made to the previously proposed adjustment. In this notification, we will inform the hospital that they can request a meeting with the administrative adjustment review panel and that such a request must be submitted by a due date that we will specify. (The panel is described in §28050 below.) The specified due date will not be less than one month and not more than three months from the date of this notice.

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If we do not receive a request for a meeting from the hospital by the due date, we will deem our proposed adjustment accepted by the hospital and we will adjust the hospital's payment accordingly.

If the hospital requests a meeting with the review panel, we will contact the hospital to schedule a meeting.

We will not schedule a meeting with the administrative adjustment review panel until the hospital and us have attempted to reach an agreement on a disputed adjustment. We will schedule a meeting at the hospital's request only after the hospital has submitted a disagreement to our initial or first adjustment proposal and: (a) we have either responded to the hospital with at least one revised adjustment which they do not accept, or (b) we have notified the hospital that we will not change the proposed adjustment.

28042 If We Revise a Disputed Adjustment.

If we revise a disputed adjustment, we will send our revised adjustment and supporting worksheets to the hospital. With our proposing a revised adjustment, the procedures described in §28030 and §28040 above will be used for notifying the hospital and handling any disputes the hospital may have with the revision.

28050 Administrative Adjustment Review Panel

The administrative adjustment review panel serves as an advisory group to the director of the Bureau of Health Care Financing (BHCF) for final decisions on disputed administrative adjustments. The panel will be chaired by a designee of the director and will consist of at least four other staff of the BHCF. Panel members will be appointed by the director or his/her designee and will not necessarily be the same persons for each meeting or case. Up to two staff persons who are directly involved in hospital rate setting may be, but need not be, on the review panel. The staff person or persons who calculated the adjustment will not be on the review panel.

Meetings of the review panel will be scheduled with hospital consultation. The hospital's representatives may attend the meeting in person or may meet with the panel through a teleconference. In addition to meeting with the panel, the hospital's representatives may provide written position papers and other information regarding their case.

The meeting will be an informal fact finding meeting under the control and direction of the chairperson of the review panel. The BHCF staff person(s) who calculated the adjustment will explain their calculations and policy considerations and answer inquires from the panel and from the hospital's representatives. The hospital's representatives will be given the opportunity to present the hospital's case and answer inquires from the panel members and from the BHCF staff person(s) who calculated the adjustment. After hearing the presentations, the review panel will develop a recommendation for the director of the BHCF that may include or be based on a revised calculation prepared at the direction of the panel. The panel may discuss the case without the presence of the hospital's representatives.

The BHCF director or his/her designee will make the final decision on the adjustment and will send notice of the decision to the hospital.

End of Administrative Adjustment Procedures.